MALE FAMILY PLANNING HEALTH HISTORY FORM

Please answer the questions below: ***(Do not urinate before exam!)***

Last Name	First	Date of birth:	Age:	Date today:

Home phone number: ( )	Message/pager number: ( )	Best time to call:

What is the main reason for your visit today?_____

Are you allergic to any medicines? ❒ YES ❒ NO *Which ones and describe what happened:*

Do you take medicines, natural remedies, aspirin, or other drugs every day? ❒ YES ❒ NO
List them:

Are you up to date with your immunizations like Rubella and Hepatitis B? ❒ YES ❒ NO ❒ Unknown

Do you use tobacco? ❒ YES ❒ NO How much do you use? _____ How many years? _____
Do you drink alcohol? ❒ YES ❒ NO How often? ❒ daily ❒ weekly ❒ monthly
How many alcoholic drinks do you have? ❒ 1-2 drinks ❒ 3-4 drinks ❒ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine, or IV drugs)? ❒ YES ❒ NO
What do you use? _____ How often? ❒ daily ❒ weekly ❒ monthly

Have you ever had or do you have:
High blood pressure ❒ YES ❒ NO Hepatitis *(turned yellow)* ❒ YES ❒ NO
IV drug use ❒ YES ❒ NO Problems with your kidneys or bladder ❒ YES ❒ NO
Any other serious medical condition ❒ YES ❒ NO

Have you ever had a sexually transmitted disease or genital infection? ❒ YES ❒ NO
(circle the ones you think you might have had)

Chlamydia	Gonorrhea	Herpes	Genital Warts
Syphilis	HIV	Jock itch	Hepatitis B or C

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape, we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

How many different sex partners have you had in the last 12 months? _____

Were your partners *(circle):* women men both IV drug user bisexual a partner with multiple sex partners or at risk for HIV or STD

How long have you been with your current sex partner(s)? _____

What type of sex have you had in the past 2 months? *(circle the types)*
Vaginal Oral Anal Other No sex

Are you and your current sex partner(s) using a birth control method *(if any of your sex partners are female)*
If so, what kind? _____

Do you have symptoms of a genital infection? ❒ YES ❒ NO *(circle the ones you have)*

Rash	Itch/Pain	Pain with urination	Urgent or frequent urination	Stool or anal problems
Bumps	Burning	Sores	Drip/Discharge	Rectal bleeding

Have you had sexual contact with a person with a postive STD test? ❒ NO ❒ YES
Have you had a postive STD test in the last year? ❒ NO ❒ YES
Date of your last sexual contact? _____ Did you use a condom? ❒ YES ❒ NO
Have you used condoms before? ❒ YES ❒ NO
How many hours since you last urinated?_____

Reviewed by: _____

Date: _____

Chart Label

Public Health
Seattle & King County

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